



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Fondren Orthopedic Group

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-14-1551-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 31, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim ... was the only one that we billed for this amount it appears that the carrier denied this as a visit already billed but we have gone back and see that patient was only seen by one doctor here at Fondren. Therefore we are requesting that you resubmit this claim for payment."

Amount in Dispute: \$112.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 10, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2013	Evaluation & Management, established patient (99213)	\$112.25	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 53 – Two evaluations/visits have been inappropriately billed on the same date of service.

- B14 – Payment denied because only one visit or consultation per physician per day is covered.
- W1 – Workers compensation state fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.

Issues

Does a dispute exist for the services in question?

Findings

The requestor is seeking reimbursement of \$112.25 for CPT code 99213 on date of service March 25, 2013. Per the Explanation of Benefits dated May 29, 2013, the insurance carrier reimbursed \$118.65 for the services in question, which exceeds the disputed amount. Therefore, the Division finds that no dispute exists for the services in question. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	December 8, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.